CHAPTER 20 - FRAUD AND ABUSE

REVISION DATE: 4/16/14

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: 42 CFR 455.2; A.R.S. §§ 46-451 and 13-3623

The Division is committed to the prevention and detection of fraud and abuse. As providers, you are responsible to administer internal controls to guard against fraud and abuse.

Abuse of the Program

Abuse is defined by Federal law (42 CFR 455.2) as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Abuse of a Member

Abuse of a member, as defined by Arizona law (A.R.S. §§ 46-451 and 13-3623), means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Definition of Fraud

Fraud is defined by Federal law (42 CFR 455.2) as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of Fraud

Falsifying Claims/Encounters: Alteration of a claim; incorrect coding; double-billing; or false data submitted.

Falsifying Services: Billing for services/supplies not provided; misrepresentation of services/supplies; or substitution of services.

Administrative/Financial: Kickbacks; falsifying credentials; fraudulent enrollment practices; fraudulent Third Party Liability (TPL) reporting; or fraudulent recoupment practices.

Member Issues (Fraud) Eligibility Determination Issues: Resource misrepresentation (transfer /hiding); Residency; or household composition.

The Division will:

A. review all participating providers during the credentialing/certification process (including re-credentialing); and

B. monitor providers for non-compliance with Division contracts, rules, policies and procedures, in addition to AHCCCS policies.

Prior Authorization includes verification of:

A. member eligibility,

B. medical necessity,

C. appropriateness of service being authorized,

D. the service being requested is a covered service, and

E. an appropriate provider referral.

The Division's electronic claims processing application executes over 150 payment edits ensuring payment accuracy and guarding against fraud and abuse. Some of these edits include: member eligibility; covered services; prior authorization; appropriate services codes; dates of services; authorized units and units provided; duplicate claims; approved rates; and utilization.

The Division, with the support of the Department's Audit and Management Services Division, conducts post payment reviews. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These reviews include the review of provider files, such as timesheets, to ensure proper documentation.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as needed basis.

If at any time during the above processes, an unusual incident is suspected or discovered, the matter is referred to the Department's Fraud Coordinator.

Reporting Procedures

When a provider discovers or becomes aware of an incident of potential/suspected fraud or abuse, the provider shall immediately report the incident to the Division.

Fraud and Abuse of the Program

To report suspected fraud or abuse of the program:

A. Call the toll free DES/DDD Hotline at 877-822-5799

B. Report the incident by completing the online referral form at: https://www.azdes.gov/forms.aspx?menu=96&form=7105

Abuse of a Member

Providers shall comply with mandatory reporting requirements in accordance with A.R.S. §13-3620 for children under age 18, and A.R.S. §46-454 for adults, as outlined in Chapter 2000 of the Division's Policy and Procedure Manual. (https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/2000.pdf)

In addition, providers shall report to the Division all incidents of suspected abuse of a member in accordance with the policy and procedures detailed in Chapter 2100. (https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/2100.pdf)